

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-030432

STATE FILE NUMBER

AMENDED

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 204

FILED AUG 23 1961

DATE AMENDED

9/18/61

Congestive heart failure

Hemorrhage

Blood loss anemia

INSTEAD OF

Congestive heart failure

Hemorrhage

Blood loss anemia

SHOULD READ

Hyaline Membrane Disease

should be left blank

Pt. II 1. Prematurity, 2. Blood loss anemia

ITEM NO.

18a

18b

Pt. II 1. Prematurity, 2. Blood loss anemia

BY AFFIDAVIT OF attending physician

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>St Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>St Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Charles</u>		c. CITY OR TOWN <u>DEFIANCE</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Joseph's Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>Rt. 1 Box 104</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Layton</u> Last <u>Cunningham</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-61</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (City and state or country) <u>St. Charles, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>Kenneth Cunningham</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ann Oliver</u>	
14. NAME OF HUSBAND OR WIFE <u>NONE</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Father -</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Hemorrhage</u> DUE TO (c) <u>Hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>40hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>1. Prematurity 2. Blood loss anemia</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>9</u> a.m. <u>00</u> p.m. Month, Day, Year <u>8-15-61</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>St Charles</u>	
20g. COUNTY <u>St Charles</u>		20h. STATE <u>MO</u>	
21. I attended the deceased from <u>8-15-61 9:00AM</u> to <u>8-16 3:20 PM</u> and last saw him alive on <u>8-16</u> . Death occurred at <u>3:20</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R. C. Hammond, M.D.</u>		22b. ADDRESS <u>207 N. 5th St Charles</u>	
22c. DATE SIGNED <u>8-16-61</u>		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>8-17-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOCAL CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>Quincy, Mo.</u>
24. FUNERAL DIRECTOR <u>LANDESS FUNERAL HOME, CAMPBELL, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>Aug 16 - 61</u>	
26. REGISTRAR'S SIGNATURE <u>Mareeena Wilson</u>		26. REGISTRAR'S SIGNATURE	

(Licensed Embalmer's Statement on Reverse Side)

OCT 25 1962

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John J. Haines

Licensed Embalmer No. 4108

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.